

Arthur L. Pincus

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TO HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
6765											
06751											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 9 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 32 South Court						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 32 South Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie Elizabeth Whalen Ambush						4. DATE OF DEATH Month Day Year June 22 19 61					
5. SEX Female		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9-1864		9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Frederick-Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Whalen						14. MOTHER'S MAIDEN NAME Jane Swann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-24-9844B				17. INFORMANT Address Bertha Delauter-32 S. Court St. Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 22, 1961 to June 22, 1961 , that (I) (we) last saw the deceased alive on June 22, 1961 , and that death occurred at 5:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Henry V. Chase 22c. PHYSICIAN'S NAME (Type) H.V. Chase						22b. DATE SIGNED June 22, 1961		22d. ADDRESS 4-East Church St. Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-26-61		23c. NAME OF CEMETERY OR CREMATORY Point Of Rocks		23d. LOCATION (City, town or county) (State) Frederick-Co. Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks						25a. REC'D BY REGISTRAR JUN 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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00751

Providence

Providence

Providence

Providence

Providence

Providence

32 South Court

32 South Court

Annie Elizabeth Whalen Amburn

Annie Elizabeth Whalen Amburn

June 28

68

Aug. 7-1884

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U

Female

Housewife

Providence

Providence-30, Mass.

U.S.A.

William Whalen

John Swann

Providence, R.I.

No

218-24-9844B Bertha Deland-12 & Court St,

Handwritten notes and signatures

Handwritten notes and signatures

Handwritten notes and signatures

M.V. Chase

4-Best Church St. Providence, R.I.

6-28-84

Point of Noctua

Providence-30, Mass.

U.S. Census 1880

Providence, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06752

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		1 d. STREET ADDRESS X Rocky Ridge	
3. NAME OF DECEASED (Type or print) First Middle Last Annabelle Baker		4. DATE OF DEATH Month Day Year June 16 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1898
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Shriner		14. MOTHER'S MAIDEN NAME Laura ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wilson Baker		Address Rocky Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Diabetes mellitus 2. Obesity			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14, 1961 , to June 16, 1961 , that I last saw the deceased alive on June 16, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		M.D. H.E. Church St DATE SIGNED 6/16/61	
PHYSICIAN'S NAME (Type) Henry V. Chase		Frederick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-20-61	22c. NAME OF CEMETERY OR CREMATORY Church of Brethren Cem.	22d. LOCATION (City, town, or county) (State) Rocky Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crugn		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR JUN 20 61		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6767

06753

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7 c. LENGTH OF STAY IN 1b Since 5/3/57 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montevue				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6 d. STREET ADDRESS Meadow Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) OLIVER MILTON BAKER			4. DATE OF DEATH Month June Day 27 Year 1961								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH 19 July 1877		9. AGE (In years last birthday) 83 yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Fur Dealer		11. BIRTHPLACE (County & State, or foreign country) Maryland							
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John M. Baker								
14. MOTHER'S MAIDEN NAME Mary Margaret Covell			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No								
16. SOCIAL SECURITY NO. None			17. INFORMANT Oliver T. Kolb, 607 Grant Place, Frederick, Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 </td> <td style="width: 70%;"> Chronic myocarditis Atherosclerosis </td> </tr> <tr> <td> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> DUE TO (b) DUE TO (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1	Chronic myocarditis Atherosclerosis	CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) DUE TO (c)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1	Chronic myocarditis Atherosclerosis										
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma Colon											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 23, 1961 to June 23, 1961 , that (I) (we) last saw the deceased alive on June 23, 1961 , and that death occurred at 5:30A , from the causes and on the date stated above.											
22a. SIGNATURE H. F. Kline				22b. DATE SIGNED 28 June 1961							
22c. PHYSICIAN'S NAME (Type) H. F. Kline, M. D.				22d. ADDRESS 7 N. Market St., Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-30-61		23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery							
23d. LOCATION (City, town or county) (State) Near Frederick, Maryland				24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland							
25a. REC'D BY REGISTRAR JUN 30 '61		25b. REGISTRAR'S SIGNATURE Charles S. Frame									

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 is retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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J. E. Robinson & Son, Frederick, Maryland

6-20-01
Hornet General Cemetery
New Frederick, Maryland

J. F. Lingo, N. D.

J. E. Lingo, N. D., Frederick, Md.

25 Jan 1901

Wm. S. Lingo

Frederick, Md.

Frederick, Md.

Frederick, Md.

Home

Oliver A. Lingo, Frederick, Md.

Carl Lingo, Frederick, Md.

Harry Lingo, General

For Lingo

Frederick

Frederick

Frederick

Home

Frederick

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6763

06754

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Vindabona Nursing Home				d. STREET ADDRESS 9 East "A" Street			
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Barger				4. DATE OF DEATH Month 6 Day 18 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-2-1894	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Passenger Conductor B.&O.				10b. KIND OF BUSINESS OR INDUSTRY Conductor B.&O.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Loander Barger				14. MOTHER'S MAIDEN NAME Elizabeth Reed			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No				16. SOCIAL SECURITY NO. 420-1			
17. INFORMANT Mrs. Lottie Barger, Brunswick, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia & failure DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable Bronchitis & Lung						INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 61 to 6/18 , 19 61 , that (I) (we) last saw the deceased alive on 6/16 , 19 61 and that death occurred at 6/18 , 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE A. L. Brice M.D.				22b. DATE SIGNED 6/18			
22c. PHYSICIAN'S NAME (Type) A. L. BRICE				22d. ADDRESS St. Joseph's Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Park Heights		23d. LOCATION (City, town or county) (State) Brunswick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				25a. REC'D BY REGISTRAR DATE JUN 23 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten notes:
The following is a list of the names of the persons who have been identified as having been in contact with the subject of this investigation.
The names are listed in alphabetical order.

Handwritten notes:
C. J. [unclear]
[unclear]
[unclear]

Handwritten notes:
[unclear]
[unclear]
[unclear]

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6769

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06755

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>X Rural, Woodboro</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE VIRGINIA BARTON</u>				4. DATE OF DEATH Month Day Year <u>June 6 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29, 1912</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John C. Roderick</u>				14. MOTHER'S MAIDEN NAME <u>Amanda E. Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>John W. Barton, Woodboro, R.F.D., Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1961</u> to <u>June 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1961</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. H. Missler</u>				22b. DATE SIGNED <u>June 6, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. H. Missler</u>				22d. ADDRESS <u>Union Bridge Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/8/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>				23d. LOCATION (City, town, or county) (State) <u>xx. Woodboro, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. Barton, Walkersville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

5762

IN

YANNIE ALBANA
FEBRUARY 20 1900
BORN FEBRUARY 20 1860
DIED FEBRUARY 20 1900
AGE 39 YEARS
CAUSE OF DEATH
DISEASE

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6770

06756

1. PLACE OF DEATH a. COUNTY <u>Fredericks</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beulah P. Boyer</u>				4. DATE OF DEATH <u>June 26 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1899</u>	
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Charles W. Ahalt</u>				14. MOTHER'S MAIDEN NAME <u>Pearl M. Boyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Carroll E. Boyer, Middletown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 13 1961</u> , to <u>June 26 1961</u> , that (I) (we) last saw the deceased alive on <u>June 26 1961</u> , and that death occurred at <u>2:10</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Henry V. Chase</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				22d. ADDRESS <u>4 E. Church St Frederick, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6/28/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gladhill Company, Middletown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. E. Boyer</u>	

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Frederick

✓ **Thurmont**

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Yes

IF UNDER 24 HRS	
Hours	Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME
Alice ?

17. INFORMANT	Address
Donothy M. Broadbent	Thurmont, Md.

INTERVAL BETWEEN
ONSET AND DEATH

1 yr

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)

(Stote

22b. DATE
SIGNED

46 Church St Frederick Md

23d. LOCATION (City, town, or county) (State)

25b REGISTRAR'S SIGNATURE

Gallus 2 Head

CERTIFICATE OF DEATH

1911



Frederick

Frederick

Frederick

Frederick

2 yrs.

1 yr.

Frederick Memorial Hospital

4 Main St.

Male - White

Nov. 12, 1911

U.S.A.

John Hopkins Res.

Frederick

Less Broadmont

Alice

Frederick Memorial Hospital, Md.

100-2-2-1

Yes



Frederick, Md.

Blue Ridge, Maryland

6-1-11

Frederick, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

06758

6772

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Collogee Park 1671-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Francis Scott Key Hotel		d. STREET ADDRESS 4704 Fordan Road	
3. NAME OF DECEASED (Type or print) Irvin First Cecil Middle Brown Last		4. DATE OF DEATH June 21 Month 6 Day 19 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1895
9. AGE (In years birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	11. BIRTHPLACE (State or foreign country) Ringgold Co, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick F. Brown	
14. MOTHER'S MAIDEN NAME Minnie E. Reffner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1st. W.W.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Irvin C. Brown, Collogee Park, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH hour year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		20i. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thoas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thoas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 22, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 6/24/61		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Plainsville		22d. LOCATION (City, town, or county) (State) Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUN 26 '61	
24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, the certificate should be executed within 72 hours after death. If the certificate is not executed within 72 hours after death, it shall be void. The certificate should be executed in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for your files. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1900		New York City		123 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Date of Death		Place of Death		Physician's Name		Hospital Name		Coroner's Name	
Teacher		High School		Married		Jan 15, 1945		New York City		Dr. J. Smith		St. Mary's		John Doe	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician		Signature of Family		Signature of Witness		Signature of Registrar		Signature of Clerk		Signature of Nurse	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MAY 1945

TO HOSPITAL. The law requires that the death certificate be filed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL

VR A15 (4)
15M 9/60

(M)

DR. HARP
MIDDLETOWN

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOLIVER - RURAL</u> c. LENGTH OF STAY IN 1b <u>VALLEY VIEW NURSING HOME</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>VALLEY VIEW NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence Before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BROWNISVILLE</u> d. STREET ADDRESS <u>MAIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LELULA BROWN</u>			4. DATE OF DEATH <u>JUNE - 21 - 1961</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>OCT-14-1866</u>			9. AGE (In years last birthday) <u>94</u> yrs.			10. IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			11. BIRTHPLACE (County & State, or foreign country) <u>FINKSBURG CARROLL CO. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN STOCKSDALE</u>			14. MOTHER'S MAIDEN NAME <u>RUDOLPH S. BROWN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>NO RECORD</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Generalized Arterio Sclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>450.0</u> DUE TO (c) <u>450.0</u>			INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>April 1958</u> to <u>June 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1961</u> , and that death occurred at <u>405</u> from the causes and on the date stated above.			22a. SIGNATURE <u>J. Elmer Harp</u> (M.D.)		
22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <u>J. ELMER HARP</u>			22d. ADDRESS <u>Middletown, Md</u>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JUNE 23 1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>BROWNISVILLE WASH. CO. MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>			24b. ADDRESS <u>BOONSBORO MD</u>			25a. REC'D BY REGISTRAR <u>JUN 29 '61</u>			25b. REGISTRAR'S SIGNATURE <u>James S. Harris</u>		

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VALLEY VIEW PARKING HOME

JUNE 1971

BROWN

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HOUSE WIFE OWN HOME PARKING HOME TO MD-11254

STOCKDALE

NO MOVIE ROOMS BROWN BROWN EASTON MD

John G. Galt, Rockford, MD

John G. Galt, Rockford, MD

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MAY 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monocacy Hall Nursing Home (N. Market St.)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) First Ada Middle Elizabeth Last Bussard		4. DATE OF DEATH Month JUNE Day 9 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 72 Days 12 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick Co. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William N. Sweeney		14. MOTHER'S MAIDEN NAME Elizabeth Holt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs Pauline Dorsey Woodsboro. Address MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15 19 61 to 6/7 19 61 , that (I) (we) last saw the deceased alive on 6/7 19 61 , and that death occurred at 11:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds, M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/10/61	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D.		22d. ADDRESS 9 E. Church St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 12-1961	
23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		23d. LOCATION (City, town, or county) (State) Thurmont. Fredk. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Buag ADDRESS Thurmont. MD		25a. REC'D BY REGISTRAR DATE JUN 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
06761										
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville					c. LENGTH OF STAY IN lb 30yrs					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersville d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) John William Caniford					4. DATE OF DEATH Month 6 Day 15 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-1899		9. AGE (In years last birthday) 61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) Yard master B.&O.R.R.Co.					11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James W. Caniford					14. MOTHER'S MAIDEN NAME Lucy Conner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 705-09-3121					17. INFORMANT Mrs. Minnie Caniford, Knoxville, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cronary occlusion (c) Extensive Cronary sclerosis					INTERVAL BETWEEN ONSET AND DEATH 10 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-15-61 , 19 61 , to 6-15-61 , 19 61 , that (I) (we) last saw the deceased alive on 6-15-61 , 19 61 , and that death occurred at 11 A.M., from the causes and on the date stated above.										
22a. SIGNATURE C. E. Prvitt					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-17-61			
22c. PHYSICIAN'S NAME (Type) Brunswick, Md					22d. ADDRESS Brunswick, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-18-1961		23c. NAME OF CEMETERY OR CREMATORY Saint Marks			23d. LOCATION (City, town or county) (State) Petersville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE B. Hu Felt					25a. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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TO HOSPITAL, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
6776 CERTIFICATE OF DEATH 6/12/61 iwk 06762											
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb 20 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 233A Phebus Ave						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 233A Phebus Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert			Middle Clifton			Last Cartnail			4. DATE OF DEATH Month 6 Day 4 Year 19 61		
5. SEX Male		6. COLOR OR RACE negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-1895		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 8 IF UNDER 24 HRS. Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Frederick, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas Cartnail						14. MOTHER'S MAIDEN NAME Ruth Kilgo					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-10-0565-H		17. INFORMANT Ruth Cartnail		Address 233 Phebus Fred			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart failure 433.1 DUE TO Atrial fibrillation + mitral & aortic valv. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Probable Rheumatic Fever PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH 1960 1954 ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 1961		(County) Frederick		(State) Md
21. I certify that (I) (this hospital) attended the deceased from June 3, 1961 to June 4, 1961 , that (I) (we) last saw the deceased alive on June 3, 1961 , and that death occurred at 7:4 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles A. Conley Jr						M.D. 5 June 1961		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. E. HICK III						22d. ADDRESS Frederick Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-6-61		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) Frederick		(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. HICK III						ADDRESS Frederick Md		25a. REC'D BY REGISTRAR DATE JUN 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00762

(M)

(I)

Handwritten notes and signatures, including a large signature at the bottom.

Handwritten notes and signatures, including a large signature at the bottom.

Handwritten notes and signatures, including a large signature at the bottom.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6777

06763

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 06X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hepsey Middle L. Last Condon				4. DATE OF DEATH Month June Day 11 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1899	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61 Days 11 Hours 19 Min.		11. IF UNDER 24 HRS. Months 61 Days 11 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Howard Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles W. Nicholson				14. MOTHER'S MAIDEN NAME Almeda Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-40-7466		17. INFORMANT Mrs. Mauree Van Sant, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema and shock 465X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Pulmonary embolus DUE TO (c) 2 hours 2 hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the gall bladder with metastases							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 , to June 11, 1961 , that (I) (we) last saw the deceased alive on June 11, 1961 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Henry V. Chase				22b. DATE SIGNED 6/11/61			
22c. PHYSICIAN'S NAME (Type) Henry V. Chase				22d. ADDRESS 4 E. Church St Frederick Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-1961		23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				25a. REC'D BY REGISTRAR DATE JUN 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

02762

DEATH DATE OF DEATH

0277

Carroll

Harvey

Frederick

Frederick

1. Frederick

Frederick Hospital

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00762

Proctor

Maryland

Rocky Ridge, D.C.

Life

Proctor

Rocky Ridge, D.C.

M



x

18 - 01

June

Deaths

Ellis

1910

50

July 15, 1910

x

Ellis

R. R. Laborer

Edward Jones

S. W.

Yes

217-00-0085 Mrs. Allen Davis

One shot wound - 2nd rib - 1st rib

Proctor

Self inflicted wound of skull - brain

July 15, 1910

Ellis

2-4-10 6/10/10

1910

S. W. Jones, D.C.

One shot wound - 2nd rib - 1st rib

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6779

06765

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN TB 50 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Nathan Dubel		4. DATE OF DEATH June 7, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1884	
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Lawson A. Dubel		14. MOTHER'S MAIDEN NAME Rena E. Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0775A	
17. INFORMANT Mary E. Miller		Address I6II Rosemont, Frederick Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse thrombophlebitis + gangrene toe (c) diabetes - uncontrolled		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 days - 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-5-61 , 19 61 , to 6-7, 1961 , that (I) (we) last saw the deceased alive on 6-5-61 , 19 61 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Love		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas A. Love		22d. ADDRESS 14 W Main St. Thurmont Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem		23d. LOCATION (City, town or county) (State) Frederick MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Crager		25a. REC'D BY REGISTRAR JUN 12 '61	
ADDRESS Thurmont, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

Frederick

MS

Frederick

Frederick

50 yrs

Frederick

Gen. Hens

1811 Rosemont Avenue

James Nathan Tubel

James Nathan Tubel

June 7, 1961

Male

White

x

January 7, 1961

Electroplater

Self employed

Frederick Co. Md

U.S.A.

Lawson A. Tubel

Reps. E. Miller

No

517-10-077 James E. Miller 1811 Rosemont, Frederick

10.30PM

Burial

June 10, 1961

Frederick Md.

Thurmont, Md

US 111

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6780

CERTIFICATE OF DEATH

06766

Item 9 Film G288 6/12/61 iwk

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6 c. LENGTH OF STAY IN 1b 7 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Linganore Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6 g. STREET ADDRESS Linganore Road h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle DEANS Last FINCH				4. DATE OF DEATH Month June Day 4 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Feb 1914	
9. AGE (In years last birthday) 47 1/2 yrs.		10. IF UNDER 1 YEAR Months 4 Days 18 Hours 15 Min.		11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner & Operator Tree Surgeon & Landscaping				10b. KIND OF BUSINESS OR INDUSTRY Wilson, N. C.			
13. FATHER'S NAME Francis J. Finch				14. MOTHER'S MAIDEN NAME Mary Deans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Janie P. Finch (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIOGENIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonectomy done at Johns Hopkins Hospital 3 weeks ago.				INTERVAL BETWEEN ONSET AND DEATH one month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/3 , 19 61 , to 6/4 , 19 61 , that (I) (we) last saw the deceased alive on 6/3 , 19 61 , and that death occurred at 3:30A , from the causes and on the date stated above.							
22a. SIGNATURE Richard C. Reynolds				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 5 June 1961	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds				22d. ADDRESS 9 E. Church St., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-7-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR JUN 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hurd	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1930

1930

Frederick

Frederick

Frederick

Frederick - General

Frederick - General

Frederick - General

Frederick - General

Frederick - General

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(I)

Frederick C. Reynolds

Frederick C. Reynolds

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Frederick & Son, Frederick, Maryland

Frederick & Son, Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06767

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Rt. 2		c. LENGTH OF STAY in 1b 5 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Route 2		d. STREET ADDRESS Unionbridge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Unionbridge				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles Luther Fisher				4. DATE OF DEATH Month June Day 18 Year 1961				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1-1889		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook - Retired		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3562		17. INFORMANT Ida Fisher-Rt.2 Unionbridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Months Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1960 to 6/18/61 , 19..., that (I) (we) last saw the deceased alive on June 1, 1961 , and that death occurred at 6:25 PM , from the causes and on the date stated above.								
22a. SIGNATURE C. E. Hicks				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/20/61		
22c. PHYSICIAN'S NAME (Type) C. E. Hicks				22d. ADDRESS Union Bridge, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-61		23c. NAME OF CEMETERY OR CREMATORY Waymans		23d. LOCATION (City, town or county) (State) Mt. Pleasant Fred. Co. Md.		
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks 111				25a. REC'D BY REGISTRAR JUN 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL: Retained by the hospital or attending physician. The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

(1)

Frederick

Rural - Rt. 2

Unknown

Charles

Wife

Cook - married

Unknown

No

2 yrs.

Wife

Wife

Maryland

Rural Route 2

Unknown

Wife

July 1-1888

VI

Frederick Co, Md.

Unknown

814-10-1888 for Fisher-Rt. 2 Unknown, Md.

00787

Frederick

St. Pleasant Fred. Co, Md.

8-21-01

G.M. Hicks III, Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6782

06768

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Middletown c. LENGTH OF STAY IN 1b 5 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Valley View Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland f. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH EBY FLOOK		4. DATE OF DEATH Month June Day 22 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Farmersville, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Eby		14. MOTHER'S MAIDEN NAME Elizabeth Sheidler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Elizabeth MacGregor, Allentown, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 29, 1961 , to June 22, 1961 , that (I) (we) last saw the deceased alive on June 20, 1961 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE J. Elmer Harp		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. Elmer Harp		22d. ADDRESS Middletown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24, 1961	
23c. NAME OF CEMETERY OR CREMATORY United Brethren		23d. LOCATION (City, town or county) (State) Myersville Fred. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		25a. REC'D BY REGISTRAR DATE JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL: The law requires that the death certificate be secured within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6783 CERTIFICATE OF DEATH 06769

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Since-1915 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 119 West Fourth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EDNA GRACE FOGLE		4. DATE OF DEATH Month Day Year June 30, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 June 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Franklinville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Eigenbrode		14. MOTHER'S MAIDEN NAME Rosilla C. E. Matthews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James R. Fogle (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 430.0 Acute bacterial endocarditis IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 12 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19 , 19 61 , to 6/30 , 19 61 , that (I) (we) last saw the deceased alive on 6/30 , 19 61 , and that death occurred 10:30A , from the causes and on the date stated above.			
22a. SIGNATURE James B. Thomas M.D.		22b. DATE SIGNED 1 July 1961	
22c. PHYSICIAN'S NAME (Type) James B. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-3-61	
23c. NAME OF CEMETERY OR CREMATORY United Brethren Cemetery		23d. LOCATION (City, town or county) (State) Thurmont, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE JUL 5 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6784

06770

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 500 Grant Place				d. STREET ADDRESS 500 Grant Place			
3. NAME OF DECEASED (Type or print) First Middle Last SADIE EDITH FULMER				4. DATE OF DEATH Month Day Year June 15, 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 16 Dec 1891		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Walkersville, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME (First name unknown) Stultz			
14. MOTHER'S MAIDEN NAME Annie Eyler				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-22-9506				17. INFORMANT Address Marshall H. Fulmer (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary occlusion</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="width: 70%;"> (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary occlusion</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>Arteriosclerotic heart disease</i> DUE TO (c)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary occlusion</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>Arteriosclerotic heart disease</i> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>Nov 2</i> to <i>June 15, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 15, 1961</i> , and that death occurred at <i>2 P</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Henry V Chase</i> M.D.				22b. DATE SIGNED 16 June 1961			
22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.				22d. ADDRESS 4 E. Church St., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-19-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			
23d. LOCATION (City, town or county) (State) Frederick, Maryland				24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			
25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in a hospital or attending physician, the certificate may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Mitchell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT DETRIK - FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>7 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ward - 200, W RGH</u>				d. STREET ADDRESS <u>Box 264</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Greene</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 April 1918</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ampl. Sgt. Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u> </u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jim Greene (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Annie Buchanan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>1941-1957 242-40-3883</u>		17. INFORMANT (wife) Address <u>Mrs Kate Bryant Greene, Bakersville N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO <u>201X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial pneumonia.</u> DUE TO (c) <u>Hodgkins Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 Hours.</u> <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>61</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>							
21. I certify that he (this hospital) attended the deceased from <u>28 Nov. 1960</u> to <u>18 June 1961</u> , that he (we) last saw the deceased alive on <u>18 June 1961</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harry G. Dangerfield</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>18 June 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY G. DANGERFIELD</u>				22d. ADDRESS <u>Ward 200, WrgH, Fort Detrick, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>		23b. DATE THEREOF <u>6-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town, or county) (State) <u>North Car.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey & Son</u>				ADDRESS <u>Frederick, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6786

06772

1. PLACE OF DEATH a. COUNTY <u>Fredenck</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredenck</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>				d. STREET ADDRESS <u>06X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fredenck, Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Elaine</u> Last <u>Heffner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 JUNE 61</u>		9. AGE (In years lost birthday) yrs. <u>-</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Heffner</u>				14. MOTHER'S MAIDEN NAME <u>Aidena Elizabeth Engle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mother RFO 2 New Windsor Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive heart disease</u> DUE TO (b) <u>ethology</u> DUE TO (c) <u>undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>W</u> (this hospital) attended the deceased from <u>13 June 1961</u> to <u>16 June 1961</u> , that <u>4</u> (we) last saw the deceased alive on <u>16 June 1961</u> , and that death occurred at <u>6:25</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>A. M. Powell Jr</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>AM POWELL JR</u>				22d. ADDRESS <u>FREDERICK MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 17-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER</u>		23d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W D Hartzler & Sons</u>				ADDRESS <u>New Windsor</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 19 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Date of birth: [illegible]
4. Place of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Manner of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

CERTIFICATE OF DEATH

02773

1981

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State of New York
County of ...
I, the undersigned, a duly qualified and licensed ...
do hereby certify that on the ... day of ...
at ...
the following named person died:
Name of Deceased ...
Age ...
Sex ...
Race ...
Date of Birth ...
Place of Birth ...
Cause of Death ...
Signature of Physician ...
Signature of Medical Examiner ...
Signature of Registrar ...

01111

Witness my hand and seal of office this ... day of ...
at ...
Registrar of Vital Statistics
County of ...
State of New York

06774

1. PLACE OF DEATH o. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY		Carroll											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		1 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural--Mt. Airy													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Frederick Mem. Hospital		d. STREET ADDRESS		06X-2		e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year									
Jesse		W		Hood				June		25		1961											
5. SEX		M		6. COLOR OR RACE		W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
										1-9-1877		84 yrs.		Months		Days		Hours		Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Farmer-retired		10b. KIND OF BUSINESS OR INDUSTRY		owner		11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?		U.S.									
13. FATHER'S NAME		William Hood		14. MOTHER'S MAIDEN NAME		Mary Gosnell																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		----		17. INFORMANT		Mrs. Frank Byers, Mt. Airy, Md.		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		157X		DUE TO		Carcinoma of the pancreas with obstruction of bile duct		INTERVAL BETWEEN ONSET AND DEATH		6 mo.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour o. m. p. m.		19																					
21. I certify that (I) (this hospital) attended the deceased from May 29, 1961, to June 25, 1961, that (I) (we) last saw the deceased alive on June 25, 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.		22a. SIGNATURE		Henry V. Chase		M.D.		ATTENDING PHYS.		<input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS.		<input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		Henry V. Chase		22d. ADDRESS		4 E. Church St Frederick Md																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		6-28-1961		23c. NAME OF CEMETERY OR CREMATORY		Taylorsville		23d. LOCATION (City, town, or county)		Carroll Co., Md.									
24. FUNERAL DIRECTOR'S SIGNATURE		C. M. Waltz,		ADDRESS		Winfield, Md.		25a. REC'D BY REGISTRAR		DATE JUN 29 '61		25b. REGISTRAR'S SIGNATURE											

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CERTIFICATE OF ADOPTION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6789

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06775

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 31 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Lucinda Last Kane		4. DATE OF DEATH Month June Day 1 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired State employee		11b. KIND OF BUSINESS OR INDUSTRY Frederick, Maryland	
12. BIRTHPLACE (State or foreign country) U.S.A.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Richard P. Hagan		15. MOTHER'S MAIDEN NAME Mary M. Keyser	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-05-3917	
18. INFORMANT Mrs. Frances T. Stoner		Address 31 S. Market St. Fred. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 1, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 4, 1961	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR June 6 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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PAGE 20-ALB

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6790
CERTIFICATE OF DEATH

06776

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Airy d. STREET ADDRESS 600 S. Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ADA S. KIMMEL		First Middle Last		4. DATE OF DEATH June 8, 1961		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1890	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator, Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse William Severn				14. MOTHER'S MAIDEN NAME Mary C. Colwell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-05-8829			
17. INFORMANT Mr. Anthony Z. Kimmel, Jr., Same as 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 561.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lower nephron nephrosis (c) Postoperative shock						INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Strangulated inguinal hernia with obstruction of bowel						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 , to June 8, 1961 , that (I) (we) last saw the deceased alive on June 8, 1961 , and that death occurred at 9 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Henry V. Chase				22b. DATE SIGNED 9 June 1961		22c. PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.	
22d. ADDRESS 4 E. Church St., Frederick, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-11, 1961		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town or county) (State) Mt. Airy, Carroll, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

06776

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(M)

President

Navy

Secretary

Secretary

Mr. Army

President, Memorial Hospital

500 E. Main Street

Mr.

Mr.

Mr.

Mr.

Mr.

Mr.

Jan. 10, 1900

Overseas, United States, Baltimore, Maryland

James W. Davis, Secretary

(I)

215-01-5500 Mr. Secretary, U.S. Navy

Mr.

Mr.

Mr.

Mr.

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Mr.

Mr.

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Mr.

Mr.

Mr.

Henry J. Davis, Jr.

Mr. Secretary, U.S. Navy

Mr. Secretary, U.S. Navy

U.S. Navy, Washington, D.C.

Page 4
24 hours after death
The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

6791
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06777

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 1, Smithsburg		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg, Route 1		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First M. Middle Pearl Last Kline		4. DATE OF DEATH Month 6 Day 12 Year 19 61	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/1901	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Roman Wolfe		14. MOTHER'S MAIDEN NAME Laura Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harvey R. Kline, Smithsburg, Md.		Address Route 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Valcular Heart disease DUE TO Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jaw 19 54 to June 12 19 61 , that (I) (we) last saw the deceased alive on June 10 19 61 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE J. Elmer Harp		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		22d. ADDRESS Middletown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/15/k961	
23c. NAME OF CEMETERY OR CREMATORY St. Marks Lutheran Cem.		23d. LOCATION (City, town, or county) (State) Wolfsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR JUN 20 '61	
25b. REGISTRAR'S SIGNATURE Charles L. Kline			

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M

CHIEF DIVISION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6792

06778

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY in 1b Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#7 d. STREET ADDRESS Yellow Springs e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle UMFORD Last LINTON		4. DATE OF DEATH Month June Day 12 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 7 Days 6 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gas Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James W. Linton	
14. MOTHER'S MAIDEN NAME Clara Nusz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 215-20-8243		17. INFORMANT Mrs. Carrie R. Linton-Sameas Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic + rheumatic heart disease 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Flu + bronchitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs 3-4 days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to 6-12 , 19 61 , that (I) (we) last saw the deceased alive on 6-12 , 19 61 , and that death occurred at 7:15P , from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin 22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.		22b. ADDRESS North Market St., Frederick, Maryland	
22d. ADDRESS		22e. DATE SIGNED 6/14/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery		23d. LOCATION (City, town or county) (State) Frederick Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE JUN 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate is retained by the hospital or attending physician. Page 2 of this certificate is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6777

6782

III

Frederick Maryland Frederick

Frederick Frederick

Frederick Memorial Hospital Yellow Springs

White July 19, 1934 June 12, 31

I

White July 19, 1934 June 12, 31

Gar Co. Maryland USA

James H. Lincoln

415-20-213 Mrs. Curtis E. Lincoln-James Town 42

7:55P

North Market St., Frederick, Maryland

Frederick, Md.

Frederick, Md.

Frederick, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

06779

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BICKFORD LIZER		4. DATE OF DEATH Month June Day 23 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1894
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	11. IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY General labor	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Lizer		14. MOTHER'S MAIDEN NAME Clara Gaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-1943	
17. INFORMANT Mrs. Margaret Lizer, Myersville, Md. Rt. #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Valvular Heart Disease DUE TO (c) 5 Yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9-4 , 19 56 , to 6-23 , 19 61 , that I last saw the deceased alive on 6-23 , 19 61 , and that death occurred at 1:49 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Charles F. Hess M.D.		ADDRESS (Street, city or town, state) 6-24-61	
PHYSICIAN'S NAME (Type) Charles F. Hess		Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 26, 1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY United Brethern		22d. LOCATION (City, town, or county) (State) Wolfsville, Fred Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		24a. REC'D BY REGISTRAR JUN 27 1961	
24b. REGISTRAR'S SIGNATURE Charles F. Hess		DATE 6-27-61	

06772

CERTIFICATE OF DEATH

1932

(M)

Blank certificate form with horizontal lines for text entry.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6795

06781

Item 9 Form 0289 6/26/61 iwk

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 South Market Street		d. STREET ADDRESS 315 South Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Blanche V. Main Michael		4. DATE OF DEATH Month Day Year June 17, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1885
9. AGE (In years lost birthday) yrs. 75 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Frederick County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Main		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3427	
17. INFORMANT Address Mrs. Aubrey P. Baker Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis coronary arteries DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinson's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1954 , to June 17, 1961 , that (I) (we) lost the deceased alive on June 10, 1961 , and that death occurred at 114M , from the causes and on the date stated above.			
22a. SIGNATURE B. O. Thomas Jr.		22b. DATE SIGNED 6-19-61	
22c. PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Jr.		22d. ADDRESS M.D. 228 North Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-1961	
23c. NAME OF CEMETERY OR CREMATORY Reformed Church Cemetery		23d. LOCATION (City, town, or county) (State) Middletown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		25a. REC'D BY REGISTRAR JUN 21 61	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Carlton L. Kraus	

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U.S.A.

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6796

CERTIFICATE OF DEATH

Reg. Dist. No. 06782

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRAYTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BROOKFIELD NURSING HOME		d. STREET ADDRESS 08X-2	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA L. MILLS		4. DATE OF DEATH Month Day Year June 6 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. SCOTT		14. MOTHER'S MAIDEN NAME NANNIE L. SORRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN P. MILLS, Brandywine, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/7/61 , 19____, to 6/6/61 , 19____, that I last saw the deceased alive on 6/5/61 , 19____, and that death occurred at 7:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Carico		ADDRESS (Street, city or town, state) DATE SIGNED Union Bridge Md. 6/6/61	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-9-61	
22c. NAME OF CEMETERY OR CREMATORY NANJEMOY BAPTIST		22d. LOCATION (City, town, or county) (State) NANJEMOY, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Widdow, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '61	
24b. REGISTRAR'S SIGNATURE C. J. R. R.			

TO HOSPITAL QUALIFYING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death.

TO HOSPITAL QUALIFYING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death. The law requires that the death certificate be executed in 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MINTZ DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick					c. LENGTH OF STAY IN 1b 3½ Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 7 Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 7 Frederick					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Otho Middle Jackson Last Mintz					4. DATE OF DEATH Month June Day 10 Year 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1889		9. AGE (In years last birthday) 71 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Self-employed					10b. KIND OF BUSINESS OR INDUSTRY plumber		11. BIRTHPLACE (State or foreign country) Brunswick Co. N. Car.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James A. Mintz					14. MOTHER'S MAIDEN NAME Mary Emma Grissett						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 228-09-0495 B		17. INFORMANT Mrs. Alex Bryant Rt. #7 Box 80 Frederick, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident, recurrent, sudden DUE TO (b) Cerebral vascular accident DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 4 ½ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5-27-1961 , to 6-10-1961 , that (I) (we) last saw the deceased alive on 5-27-1961 , and that death occurred at 6:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Rex R Martin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Rex R MARTIN					22d. ADDRESS 220 N. MARKET Frederick, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial			23b. DATE THEREOF 6-10-61		23c. NAME OF CEMETERY OR CREMATORY Frederick, Maryland		23d. LOCATION (City, town, or county) (State) Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son					ADDRESS Frederick, Maryland						
25a. REC'D BY REGISTRAR JUN 13 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Evans						

00782

CERTIFICATE OF DEATH

1937



Frederick

Frederick

Frederick

No. 1 Frederick

No. 2 Frederick

No. 3 Frederick

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FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6798

06784

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY in 1b <u>5</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hosp.</u>				d. STREET ADDRESS <u>2729 E. Monument St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Myrna LEE E. Moore</u>				4. DATE OF DEATH Month Day Year <u>June 13 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 10, 1939</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pathologist at John Hopkins</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Moore</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Wells</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>700</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Cervical Vertebrae</u> DUE TO (b) <u>Lacerated Liver</u> DUE TO (c) <u>Fractured Skull with Subdural Hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Auto turned in front of tractor trailer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
20a. TIME OF INJURY Month, Day, Year Hour <u>7</u> p.m. <u>6/13</u> 19 <u>61</u>				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 340</u>				20d. (City or town) (County) (State) <u>Seageville Frederick Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B.D. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.D. Thomas, Md</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Baltimore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc., 6009 Harford Road</u>				24a. REC'D BY REGISTRAR <u>JUN 16 '61</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

00784

00784

DEPT. OF THE ARMY
MEDICAL DEPARTMENT

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Witnesses

Notarized Memorial

6-17-61

2001

Dr. Cook-Ritchie, Inc., 6000 Harvard Road

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
6799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06785

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural- R.D.#6			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. O. A. Frederick Memorial Hospital				d. STREET ADDRESS Linganore Road			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ROBERT MOUNT, SR.				4. DATE OF DEATH Month Day Year June 13, 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1902	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Elect. Co.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edwin Mount				14. MOTHER'S MAIDEN NAME Nona Burns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If give, give number and date of service) 214-10-5947			
17. INFORMANT Mrs. Bertha R. Mount-Same as Item #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thrombosis Coronary DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (c) 5 yrs. + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE B O Thomas M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) B. O. Thomas, M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6/14/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1961		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or country) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR JUN 16 '61		24b. REGISTRAR'S SIGNATURE William L. Thomas	

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MEDICAL CERTIFICATION

RECEIVED
HOSPITAL



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00725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

CITY OF NEW YORK

DEATH OF

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

OFFICE OF THE EXAMINER

NEW YORK

STATE OF NEW YORK

CITY OF NEW YORK

DEATH OF

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF EXAMINER

OFFICE OF THE EXAMINER

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6800

06786

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>109 West 5th Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard</u> <u>Clark</u> <u>Myers</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>22</u> <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1961</u>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel B. Myers</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hosp. records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 3-9)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 Je</u> 19 <u>61</u> , to <u>22 Je</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>21 Je</u> 19 <u>61</u> , and that death occurred at <u>245A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R L Guest</u>				22b. DATE <u>22 Je 61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. R. L. Guest</u>	
22d. ADDRESS <u>6 W 3rd St. Frederick, Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. SIGNATURE <u>22 Je 61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-23-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey & Son</u>				25a. REC'D BY REGISTRAR <u>DATE JUN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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100787

STATE OF TEXAS

100787



Frederick	Maryland	Frederick	Frederick	D.O.A. Frederick Memorial Hospital	lifetime	Frederick	Frederick
Xx	307 Fleming Avenue	Frederick	Frederick	Frederick	lifetime	Frederick	Frederick
61	June	Offutt	Louise	Texas	X	White	Female
	3	9-1-1957					
U.S.A.	Frederick, Maryland	None	None	William Jerome Offutt	None	None	None
	Laura Evelyn Woodfield						
W. Jerome Offutt 307 Fleming Ave. Frederick, Md.		None	None				

Page 4
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

6804
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06790

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle NELSON Last PONTON		4. DATE OF DEATH Month June Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Feb 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Roseland, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ponton		14. MOTHER'S MAIDEN NAME Sally Lowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Clara B. Ponton		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Advanced Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 mo 5 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 14 19 61 , to June 15 19 61 , that (I) (we) last saw the deceased alive on June 14 19 61 , and that death occurred at June 15 19 61 , from the causes and on the date stated above.			
22a. SIGNATURE A. T. Brice		22b. DATE SIGNED 15 June 1961	
22c. PHYSICIAN'S NAME (Type) A. T. Brice, M. D.		22d. ADDRESS Jefferson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-17-61	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR JUN 19 '61	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur J. Hume	

00700

CERTIFICATE OF DEATH

6004

(M)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

(1)

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]
15. Registrar's signature: [illegible]
16. Registrar's name: [illegible]
17. Registrar's title: [illegible]
18. Registrar's address: [illegible]
19. Registrar's telephone: [illegible]
20. Registrar's fax: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06791**

6805

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Airy		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <div style="text-align: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First James Middle Malcolm Last Ridgely </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month June Day 2 Year 19 61 </div>			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1961		9. AGE (in years last birthday) yrs. 2 Months 15 Days 15 Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co.			
13. FATHER'S NAME James Arthur Ridgely				14. MOTHER'S MAIDEN NAME Betty Gene Yarborough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address James A. Ridgely, Buckeystown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Empyema left side Conditions, if any, which gave rise to immediate cause (b) (c) (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 10 days ? 7 days ?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B. O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 2, 1961				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
22d. LOCATION (City, town, or county) (State) Frederick, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gailey & Son Frederick, Maryland					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE JUN 6 '61			

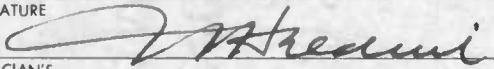


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6806

06792

(M)

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FRED. MEM. HOSP.				d. STREET ADDRESS 204 H ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DAWN Middle N. Last SIGLER				4. DATE OF DEATH Month 6 Day 22 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/60		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PAUL SIGLER				14. MOTHER'S MAIDEN NAME PEGGY HILLIARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ENDOCARDIAL FIBROELASTOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-14 1961 , to 6-22 1961 , that (I) (we) lost saw the deceased alive on 6-22 1961 , and that death occurred at 4:15 AM, from the causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FRED J. HELDRICH				22d. ADDRESS FREDERICK, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-25-1961		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS Brunswick, Maryland		25a. REC'D BY REGISTRAR DATE JUN 27 '61	
				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed 24 hours after death. The low requires that the death certificate be executed 24 hours after death. The low requires that the death certificate be executed 24 hours after death.

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CENTRICAL OF DEATH

1308

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RECEIVED THE DEPARTMENT OF HEALTH
CENTRICAL OF DEATH



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TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed in 24 hours after death. It may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John Wm. Smith
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
6807
CERTIFICATE OF DEATH

06793

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Pleasant				c. LENGTH OF STAY IN 1b year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Smith				4. DATE OF DEATH Month 6 Day 29 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 6 Days 29		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator				10b. KIND OF BUSINESS OR INDUSTRY road construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John Calvin Smith				14. MOTHER'S MAIDEN NAME M. Abbey Jennings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-10-9886		17. INFORMANT Clifford W. Smith, Route 1, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asthmatic bronchitis + emphysema, chronic 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-3-1961 to 6-29-1961 , that (I) (we) last saw the deceased alive on 6-3-1961 , and that death occurred at 9 AM, from the causes and on the date stated above.							
22a. SIGNATURE Rex R Martin				22b. DATE 6/29/61			
22c. PHYSICIAN'S NAME (Type) REX R MARTIN				22d. ADDRESS 220 N. MARKET Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 7/2/1961			
23c. NAME OF CEMETERY OR CREMATORY Locust Valley Ch. of God, Frederick Co., Md.				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				25a. REC'D BY REGISTRAR DATE 5 '61			
				25b. REGISTRAR'S SIGNATURE Charles S. Kross			

CERTIFICATE OF DEATH

6001

EDWARD J. KELLY

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EDWARD J. KELLY

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EDWARD J. KELLY

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EDWARD J. KELLY

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 6803
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
 06794

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Knoxville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>KATHY</i> Middle <i>SUE</i> Last <i>SNOOTS</i>		4. DATE OF DEATH Month <i>June</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 6, 1961</i>
9. AGE (In years last birthday) yrs. <i>4</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>30</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wilbur Calvin Snoots</i>		14. MOTHER'S MAIDEN NAME <i>JUANITA JANET PAYNE</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MOTHER</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Premature rupture of membranes</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i> <i>78 hrs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6:30 am</i> <i>19 June</i> , to <i>6:30 am</i> <i>19 June</i> , that <i>(he)</i> last saw the deceased alive on <i>6 June</i> <i>1961</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. A. M. Powell, Jr.</i>		22b. DATE SIGNED <i>6/6/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. A. M. Powell, Jr.</i>		22d. ADDRESS <i>Medical Center - Frederick</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>6-7-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LUTHERAN</i>	23d. LOCATION (City, town, or county) (State) <i>KEEFERSON MD</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kiana</i>		ADDRESS <i>Baltimore, Maryland</i>	
25a. REC'D BY REGISTRAR DATE <i>JUN 9 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kiana</i>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue Rest Home				d. STREET ADDRESS 506 North Market St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ladye Strasberger				4. DATE OF DEATH Month Day Year June 11, 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1879		9. AGE (In years lost birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Strasberger				14. MOTHER'S MAIDEN NAME Catherine Fox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-7532		17. INFORMANT Address Mr. Austin Kline 1 E. 9th St. Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arterio Sclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1940 to June 11, 1961 , that (I) (we) last saw the deceased alive on June 1, 1961 , and that death occurred at 5 PM , from the causes and on the date stated above.							
22a. SIGNATURE H F Kline				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-12, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. H. F. Kline				22d. ADDRESS M.D. 7 North Market Street Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son				25a. REC'D BY REGISTRAR DATE JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6810

06796

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb 24 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 112 West Fifth Street				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 112 West Fifth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY LOUISE TALBERT			4. DATE OF DEATH Month June Day 17 Year 1961				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 1908	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Martin L. Clem				
14. MOTHER'S MAIDEN NAME Mary E. Wills			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. 219-05-0901			17. INFORMANT Fernando Talbert (Same as item #1)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH. 10 minutes 10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (1) (this hospital) attended the deceased from 18/18 1960 to present, 1961, that (1) (we) last saw the deceased alive on 5/19 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Richard C. Reynolds M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 19 June 1961		
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.			22d. ADDRESS 9 E. Church St., Frederick, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-61		23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery			
23d. LOCATION (City, town or county) Woodsboro, Maryland		(State)					
24 FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			25a. REC'D BY REGISTRAR DATE JUN 20 '61				
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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115 East 11th Street

Ward

White

Home-work

Martin L. Oliver

At Home

Maryland

Wm. L. White

219-02-1001 (Home at 11th St)

W. S. Robinson & Son, Frederick, Maryland

Home Work Society

Woodward, Maryland

Minister & Reynolds, W. B. & J. A. Church, Jr., Frederick, Md.

19 June 1901

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Page 4
24 hours after death.
The law requires that the death certificate be executed by the attending physician or attending physician.
TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6811

06797

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, then institution) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville				c. LENGTH OF STAY IN 1b 50 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edgar Middle Allen Last Thomas				4. DATE OF DEATH Month June Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1880	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Rohrersville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work				10b. KIND OF BUSINESS OR INDUSTRY Accountant			
13. FATHER'S NAME John Aaron Thomas				14. MOTHER'S MAIDEN NAME Hannah West Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-09-2303A			
17. INFORMANT Victor Cullen State Hospital, Cullen, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002 DUE TO (b) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 29 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-1-1961 to 6-19-1961 that (I) (we) last saw the deceased alive on 6-1-1961 , and that death occurred at 4A.M. from the causes and on the date stated above.							
22a. SIGNATURE, Michael G. Zavis				22b. DATE SIGNED 6-19-61			
22c. PHYSICIAN'S NAME (Type) Michael G. Zavis				22d. ADDRESS Victor Cullen Satet Hospital, Cullen, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 22, 1961		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown Md P.M. Martin				25a. REC'D BY REGISTRAR DATE JUN 21 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

CERTIFICATE OF DEATH

Reg. Dist. No. 06798

6812

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Frederick		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, New Design Rd, Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION New Design Rd, Frederick				d. STREET ADDRESS 1 Rt 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Mae-Ellen Weedon				4. DATE OF DEATH Month 6- Day 6 Year 1961			
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-4-1880		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cannery worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Nicholas				14. MOTHER'S MAIDEN NAME Caroline Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Rachel Bowins Rt 2 Frederick Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 260X DUE TO Cerebral arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Diabetic (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1959, to June 6, 1961, that I last saw the deceased alive on June 5, 1961, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bernard O. Thomas, Jr. M.D. Frederick, Md 6/9/61							
ACTUAL SIGNATURE Bernard O. Thomas, Jr.				PHYSICIAN'S NAME (Type) Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-61		22c. NAME OF CEMETERY OR CREMATORY Sunnyside		22d. LOCATION (City, town, or county) (State) Frederick Co, Md	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks, III				ADDRESS Frederick Md		24a. REC'D BY REGISTRAR DATE JUN 12 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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